

No. 2
4-13-40
-17-39
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37503

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

DEC 22 1941 399
Registration District No. 41-399

Primary Registration District No. 1002

Registrar's No. 4298

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Jackson,
Kansas City,

(b) City or town _____
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. Luke's Hospital,
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 days,
(Specify whether _____)

In this community since 1910,
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City,
(If outside city or town limits, write "RURAL")

(d) Street No. 3526 Harrison,
(If rural, give location)

(e) If foreign born, how long in U. S. A.? X years.

3. (a) PRINT FULL NAME Mrs. Pearlana Kroh Reed,

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 17th
year 1941 hour 9:05 minute P. M.

3. (b) If veteran, name war X

3. (c) Social Security No. X

21. I hereby certify that I attended the deceased from Nov 23, 1940 to Nov 17, 1941
that I last saw her alive on Nov 17th, 1941
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced Married,

Immediate cause of death
Acute Peripheral Failure
of Vascular System
Chronic Pyelonephritis

6. (b) Name of husband or wife Franklin E. Reed,

6. (c) Age of husband or wife if alive 74 years

7. Birth date of deceased March 16 1876
(Month) (Day) (Year)

Due to _____

Due to 12 1/2

8. AGE: Years Months Days If less than one day

65 8 1 _____ hr. _____ min.

Other conditions
(Include pregnancy within 3 months of death)

9. Birthplace Kansas,
(City, town, or county) (State or foreign country)

Major findings: Bilateral Kidney
Of operations Dulcific

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

10. Usual occupation at home,

11. Industry or business X

MOTHER FATHER { 12. Name George Kroh,

13. Birthplace Pennsylvania,
(City, town, or county) (State or foreign country)

14. Maiden name Sarah Fernote,

15. Birthplace Ohio,
(City, town, or county) (State or foreign country)

16. (a) Informant Franklin E. Reed,

(b) Address 3526 Harrison, Kansas City, Mo.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

17. (a) Burial, (b) Date thereof 11-19-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Moriah Cemetery,

While at work _____ (Specify type of place)

(c) Means of injury 0

18. (a) Signature of funeral director Stine & McClure,

(b) Address 3235 Gillham Plaza, K. C., Mo.

23. Signature George O. Lee (M. D. or Pharm.)
Address 1630 Prof. Bldg Date signed 11-19-41

19. (a) 11-19-41 (b) M. M. Crook
(Date received local registrar) (Registrar's signature)

Drs. George Lee and Lee-Hoffman

Proff Balch

1 o'clock

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by

....., Registered Apprentice No.

working under my personal supervision.

Signed

E. M. Plank

Licensed Embalmer No.

1848

P. O. Address

Y. C. Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.